

**CONCESSIONER'S
MONTHLY SAFETY REPORT**
(submit with Monthly Invoice)

Date:

To: Contracting Officer's Representative

From:

Real Property / Equipment Issues: Indicate if checks have been completed and if area checked are in good operational condition. Describe checked sections in the area provided below

Completed

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1. Fire safety inspections completed (fire extinguishers, sprinkler systems, alarm systems).

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2. Existing grounds conditions (e.g. hazard trees).

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3. Check condition of lodge facilities for general condition and OSHA compliance.

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4. Recent employee/visitor injuries or near misses.

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5. Damage to government owned property.

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6. Report findings of monthly walk-through inspections.

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7. Other:

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8.

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9.

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10. **Real Property / Equipment Hazards** – The following hazards were noted and corrective action as stated has been or will be taken:

11. **Safety Related Events** – List any safety related events that have taken place during the last reporting period or are scheduled for the next reporting period. Include inspections Federal, State, or Local safety, fire safety, environmental, and health agencies. Also include any contract reporting requirements not yet addressed such as personnel certifications, training events, monthly reports, etc.)

12. **Other Issues** – List any other safety related issues.

Signature: _____
Concessioner

Date: _____

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| CONCESSIONER'S SAFETY SUMMARY REPORT | | Date: |
| To: Concessions Management Specialist From: | | |
| Complete the below summary for employees injuries, vehicle accidents, or visitors injured in your areas of responsibility during the reporting period. Use additional pages as necessary | | |
| Incident 1 | | |
| Name: | Date if Accident / Injury: | |
| Accident Location: | Position: <input type="checkbox"/> Visitor <input type="checkbox"/> Employee | |
| Accident Summary: | | |
| Accident Cause: | | |
| Corrective Actions: | | |
| Incident 2 | | |
| Name: | Date if Accident / Injury: | |
| Accident Location: | Position: <input type="checkbox"/> Visitor <input type="checkbox"/> Employee | |
| Accident Summary: | | |
| Accident Cause: | | |
| Corrective Actions: | | |
| Incident 3 | | |
| Name: | Date if Accident / Injury: | |
| Accident Location: | Position: <input type="checkbox"/> Visitor <input type="checkbox"/> Employee | |
| Accident Summary: | | |
| Accident Cause: | | |
| Corrective Actions: | | |